CHAPTER 7

The Appeals Process

This chapter provides an overview of the full appeals process for an SSI or SSDI application, from the Request for Reconsideration through an appeal in Federal court. It outlines the range of considerations an applicant should review before obtaining an attorney, and it provides guidelines for case managers who represent claimants at appeal hearings before SSA Administrative Law Judges (ALJs). Emphasis is on the outcome of the initial application; SSA reviews and appeals that occur once an individual receives benefits are not covered.

What does SSA's initial decision mean?

After SSA makes an initial determination, a letter—called a notice—is sent to both the applicant and the applicant's representative, if there is one. The letter indicates whether the applicant has been found to be disabled. If the applicant is found disabled, he or she usually will be considered disabled as of the first full month after the date of SSI application, or for SSDI, as of the date on which the person said the disability began.[1] If the applicant is found not to be disabled, the determination will apply to the entire period of time covered by the application.

In some cases, an applicant may be found disabled as of a date following the date of SSI or SSDI application. This generally occurs when SSA is unable to find an earlier date of disability based on the medical evidence in the applicant's file. Under these circumstances, the SSA notice will state that the *date of onset* (the date that a person's disability began) is later than the date on which the person applied for benefits.

While this manual does not discuss these "partially favorable" determinations in great detail, case managers should be aware that they may occur.

In all cases, the initial determination letter will include information that explains how applicants can appeal the determination. Obviously, there are few reasons one would appeal a determination that finds an

[1] As will be discussed at length later in the manual, a person who is found disabled may have payment begin effective earlier or later than the date of application.

applicant disabled.[2] On the other hand, an applicant almost always will want to appeal a determination that finds the applicant not disabled.

When an applicant is found disabled with a later date of onset, applicants will need to decide whether or not to appeal. Filing such an appeal usually is in the applicant's best interest, since he or she will receive benefits during the appeal period. If the appeal is successful, additional retroactive benefits will be paid.

However, risk is involved. At any level of appeal, SSA can reverse its previous determination. In the case of a partially favorable determination, SSA could find, on appeal, that the applicant is not disabled at all. To avoid this risk, some people choose not to file an appeal, and they accept the partially favorable determination. Case managers should present applicants with all of their options, so the applicants can make fully informed decisions on whether or not to file appeals.

The remainder of this chapter explains what a case manager should do if the applicant is found *not* disabled. Next steps to assist an applicant who is found disabled are explained in the next chapter.

What can a case manager do when an applicant is found not disabled?

If an applicant receives an unfavorable determination, or chooses to appeal a partially favorable determination, a representative or case manager can assist with filing an appeal. This initial appeal is called a *Request for Reconsideration*.[3] The Request for Reconsideration form (SSA–561) is available from the local Social Security office or on the SSA Web site at www.socialsecurity.gov/online/forms.html.[4] It can be found under the section of the page called "other forms." An appeal also can be filed by sending a letter to SSA. The letter must have the applicant's name and Social Security number on it. It does not have to be detailed; it needs only to state that the applicant wishes to appeal the determination.

The letter or Request for Reconsideration form must be supported by a Reconsideration Disability Report. This should be submitted with release forms for any additional medical sources. These forms also are available at the SSA Web site: www.socialsecurity.gov. These forms must accompany the Request for Reconsideration for a reconsideration of medical eligibility to be accepted and processed.

[2] Applicants do, however, have the right to appeal a completely favorable decision. While this occurs rarely, when it does, the applicant is often appealing because of a mental impairment that prevents him or her from understanding the importance of receiving a stable monthly income, along with health insurance. In such a situation, a case manager should work with the applicant to explain how these benefits can be used to assist in recovery. This will usually prevent applicants from seeking to file an appeal.

[3] At the time of this writing, SSA is conducting a study in 10 states, known as Disability Prototype States, in which, rather than a reconsideration as the first step of appeal, the individual can go directly to a request for a hearing before an ALJ. In these states, there is a separate set of procedures that the DDS uses before recommending an unfavorable disability determination.

[4] At the time of this writing, the Request for Reconsideration form (SSA–561) is under review by the SSA. Be aware that differences may exist between the information contained in this manual and the current SSA rules for the reconsideration process.

How is a Request for Reconsideration filed?

A case manager should follow a number of steps in filing an appeal. These are listed below.

Copy the applicant's SSA case file

When a claim is denied, the case file is returned to the SSA office where the claim was made. The file stays there for at least 65 days, until SSA knows whether the determination will be appealed. While at the office, the file is available for copying by representatives. If a case manager has filed to be a representative, he or she should call the local SSA office and arrange to copy the file. The location and phone number of the appropriate SSA office, generally the one where the claim was filed, are listed on the denial letter.

The file should contain internal DDS documents that can give representatives an idea of the decision–making process for the applicant's claim. Case managers should look for specific documentation, including:

- A log of what the analyst and medical consultant did, including medical records requested and received, third parties spoken to, and so forth;
- Psychiatric Review Technique Form (PRTF) for applicants who allege a mental illness; and
- For applicants whose denial occurred at Step 4 or Step 5, the mental and/or physical Residual Functional Capacity (RFC) assessment forms, which are completed by the medical and psychological consultants. These forms contain a series of check boxes, showing medical and psychological symptoms and conditions that were documented, as well as the degree of functional impairment that was supported by the records. These forms also may have comments by the reviewer that provide a summary of the findings and the reasoning behind such findings.

Copying the content of the file can give the case manager an important road map to follow when trying to document disability on appeal. Once the appeal is filed, however, the case file leaves the SSA office and is returned to DDS. Be sure to copy the file before filing the appeal.

File a Request for Reconsideration

The Request for Reconsideration form is one page long. It asks the applicant's name, SSI claim number (this is usually the applicant's Social Security number), the type of claim being appealed, and briefly, the relevant reasons for filing an appeal. The form also asks for the addresses of the applicant and his or her representative.[5]

Either the applicant or a representative (who has submitted an Appointment of Representative form signed by the applicant) should sign the Request for Reconsideration form. Both can sign, but it is not necessary. If an applicant's whereabouts are not

[5] The filing period is considered to be 60 days from the date of the receipt of the letter, which SSA assumes to be five days after the letter is dated.

known at the time the form must be filed, the representative should file the Request for Reconsideration while he or she tries to contact the applicant.

Organize the appeal

For a reconsideration based on medical eligibility to be accepted and processed at the SSA office and forwarded to the DDS, additional forms must be filed. A supporting form, the Reconsideration Disability Report (SSA–3441) is required, as are several other release forms for additional medical sources listed on the Reconsideration Disability Report.

The Reconsideration Disability Report seeks updated information, in the following sections:

Section 1 asks for name and contact information.

Section 2 includes questions about changes in the severity of the applicant's illness or injury since filing the original claim.

Section 3 includes questions regarding new doctors, new hospitalizations, and new agencies accessed by the applicant.

Section 4 includes questions about any medications the applicant is taking.

Section 5 asks about any new medical tests.

Section 6 asks if the applicant has worked since the last disability report. If so, SSA will ask the applicant to provide the details on a separate form.

Section 7 asks for a description of how the applicant's impairments affect his or her ability to care for him- or herself, and any changes in daily activities.

Section 8 asks if the applicant has completed any job training or vocational school since the last disability report.

Section 9 includes information on participation in the Ticket program, vocational rehabilitation, and other support services.

Submit the paperwork

When a case manager or applicant files the Request for Reconsideration, he or she should receive a date–stamped copy from the SSA field office. This helps the applicant retain proof of the date on which an appeal was filed, in case questions arise during the process. Appeal forms also can be mailed to the SSA office, certified return receipt requested; the date–stamped copy will be sent to the applicant or representative by mail.

The Request for Reconsideration must be filed at an SSA office within 60 days of the date on which the applicant receives notice of the initial determination. SSA assumes, unless an applicant can provide evidence to the contrary, that the determination is received five days after the date printed on it.

The question of timeliness is an important one. If an appeal is not accepted because it is filed too late, the applicant may have to file a new SSI application and begin the process all over again. Therefore, when filing for reconsideration, case managers should help applicants submit the forms as quickly as possible.

Submitting a late Request for Reconsideration

People who are homeless may not see a case manager right after receiving a determination notice, may lose their notices entirely, or may

not understand their right to appeal. In such situations, a case manager should work with the applicant to submit a written statement of *good cause* for missing the 60–day deadline. If SSA finds that good cause exists for failure to file a timely Request for Reconsideration, the reconsideration will be processed as if the request were filed in a timely manner.

The Request for Reconsideration must be filed within 60 days of the date on which the applicant receives notice of the initial decision.

A statement of good cause must contain one or more reasons why the applicant did not request reconsideration within 60 days. Federal regulations require SSA to consider: (1) all the circumstances that prevented an applicant from making the request on time; and (2) whether an applicant had any physical, mental, educational, or linguistic limitations that prevented him or her from filing within 60 days, or knowing or understanding that the request needed to be filed within that time period.

Frequently, people who are homeless experience problems for which they can claim good cause under both of these categories. The most common is non-receipt of a determination due to homelessness. If an applicant was unaware that a determination had been made in his or her case, then a solid argument can be made that he or she was unaware of the need to file an appeal. Other examples of difficult circumstances include a severe illness that prevented contact with SSA; a mental illness that prevented a complete understanding of the notices; or the loss of important records due to fire, theft, or some other accident.

What can case managers do after the appeal is filed?

When a Request for Reconsideration is received by the DDS, the applicant's case file is given to a new disability examiner and medical or psychological consultant team that is responsible for making the reconsideration determination. The new team will have played no role in making the initial determination.

A case manager should communicate with the new team in the same way he or she did with the examiner who made the initial determination. To find out who composes the new team, a case manager should call the DDS.

When undertaking an appeal, it is important to know that the application can be expanded to include new diagnoses or impairments that have been identified since the original application was filed. Therefore, case managers should focus on providing not only updated information about impairments already disclosed in the initial application, but also new information about impairments that may have arisen since the initial application was filed.

For example, an individual may have filed for SSI based on depression and been denied. Since that time the applicant may have discovered that she also has diabetes. While it is important to provide the DDS with additional medical records about the individual's depression, it is equally critical to provide records relating to the newly developed medical condition.

How should case managers follow up on reconsideration decisions?

The reconsideration determination will look similar to the initial determination. It will state whether or not the applicant is disabled and will briefly list the evidence considered in making the determination. If the applicant is found not disabled, and the case manager and/or applicant continue to believe that this finding has been made in error, the case manager should work with the applicant to file a second appeal. This appeal is called a Request for Hearing by Administrative Law Judge (ALJ).

How is a request for an ALJ hearing filed?

The Request for Hearing by ALJ form (HA–501) also must be filed at any SSA office within 60 days of the date on which the applicant receives the reconsideration determination.[6] Once again, a representative can sign and file the form on behalf of an applicant. And, good cause can be found for failure to file within the filing period, as described in the previous section regarding the Request for Reconsideration. The Request for Hearing by ALJ form can be found at www.socialsecurity.gov/online/forms.html.

What happens after an ALJ hearing is requested?

Once a hearing is requested, no further contact is needed with the State DDS agency. The case file is sent to a local Social Security Office of Hearings and Appeals (OHA) immediately after a hearing is requested. However, the applicant and representative may not hear from OHA for two months or more. During this time, there is no opportunity for any substantive interaction with SSA. The best way to keep track of the case is to call the OHA. As soon as the case arrives there it will be logged into the computer system. You can get the phone number for your local OHA by calling SSA's toll free number: 1-800-772-1213.

What can be done to facilitate a favorable decision?

Once the case file reaches OHA, case managers should discuss the possibility of hiring or obtaining an attorney with the applicant. While a representative need not be an attorney, the hearing before the ALJ is much more of a legal proceeding than the earlier parts of the application and appeals process.

In many places around the country, attorneys from Federally funded legal services or local legal aid programs will represent individuals at ALJ hearings. If such a program is

[6] In certain types of cases, such as when an appeal is based on non-disability issues like income, the appeals process allows applicants to choose whether their appeal will be handled through a "case review," an "informal conference," or a "formal conference." These choices are not available in cases where the issue is based on findings related to a person's disability status.

Making the Case for an Attorney

Case managers should devote the time and effort necessary to have a hearing handled by an attorney, as a hearing is a legal proceeding. A legal services attorney will not charge a fee. Other attorneys who also have expertise in social security law will charge a fee if the case is selected. Their expertise also ensures full representation and should be seriously considered if representation by a legal services attorney is not available.

available, the applicant can be represented at no charge. The attorneys and paralegals in these offices typically are skilled in preparing for and attending disability hearings. A list of Federally funded legal services programs is available at www.lsc.gov. In addition, most local SSA offices have a list of legal aid services available to the beneficiaries. A claims representative can provide a copy of the list. If a legal services or legal aid attorney cannot be found to handle the claim, the applicant may consider hiring a private attorney.

What are the pros and cons of hiring a private attorney?

Private attorneys typically represent people on a contingency basis. This means the attorney will get paid only if the claim is successful. If the claim is unsuccessful, the applicant will not owe the attorney anything. For this reason, private attorneys often will not take a case unless it is a strong one. Therefore, consulting a private attorney can provide good information about whether the applicant has a strong case or not.

If a claim is successful, under SSA rules, a representative may ask SSA for approval of a fee not to exceed 25 percent of past due benefits or $5300, whichever is less. Thus, if an applicant is eligible to receive back benefits of $10,000, the attorney can charge up to $2,500. While this reduces the amount of funds available for an individual, it is sometimes worth the price since it can improve the likelihood that an applicant will be found eligible for benefits (and obtain any health insurance benefits to which he or she may be entitled).

If an attorney takes the case, what should the case manager's role be?

If the applicant obtains an attorney, the attorney should become the applicant's representative, taking over this role from the case manager. This can be done by having the attorney complete and submit a new Appointment of Representative form. The case manager should take the steps needed to allow the attorney to take the lead in handling the case. However, as someone with detailed knowledge of the applicant and the case, the case manager should provide the attorney with all the necessary information to proceed and should consider serving as a witness at the hearing.

What if the applicant decides against having an attorney?

If the applicant decides against having an attorney or is unable to find one to take the case, it is important to understand that a case manager is still permitted to represent the applicant under SSA rules. One positive aspect of not retaining a lawyer is not having to pay a fee. On the other hand, a case manager should be aware that representatives cannot serve as witnesses at the hearing. Since the case manager may have the best understanding of the case, this might present a problem.

The balance of this chapter explains the remainder of the SSA appeals process, discussing the ALJ hearing level in some detail for case managers who represent applicants at this level. Less detail will be provided about the Appeals Council and the U.S. Federal courts, the two appeal levels following an ALJ hearing. Since representation by an attorney typically is recommended at ALJ hearings, it is also important for such representation to continue at the Appeals Council. Further, if the case goes to Federal court, a claimant is required to have attorney representation.

How can a case manager prepare for a hearing?

Representing a client in a legal proceeding is probably beyond the scope of responsibilities for most case managers. Therefore, it is important that the case manager know what to expect should he or she choose to take on that role.

What should a case manager do before the hearing?

Once a representative knows that a particular claim is at the OHA, he or she should find out the name of the judge who will be handling the case, as well as the name of the judge's hearing assistant. That may not happen immediately: Sometimes cases are not assigned for several months after they arrive at an OHA. Once the case has been assigned, the representative should contact the judge's hearing assistant to let that person know that he or she will be representing the applicant, usually referred to as the *claimant*, once a claim is filed.

After a claim file arrives at OHA, it is reorganized into a hearing file. Each piece of medical or other evidence in the hearing file is labeled as a separate exhibit so it can be referred to at the hearing. The ALJ will consider only documents associated with the hearing file.

As soon as possible, a case manager should go to OHA and arrange to copy the file. This will ensure that the case manager knows exactly what is included in the record, and can make sure that any known evidence that is not in the file is submitted in a timely fashion.

If new medical records or other evidence need to be submitted, the representative should do so in a way that provides verification that the materials were received. The representative also should submit a letter outlining the medical and legal reasons why the claimant should be found disabled. All evidence should be addressed to the judge, although once it gets to the hearing office, it will be given to the hearing assistant to place in the case file.

Case managers should submit any new medical records prior to a hearing. Records can also be submitted at the time of the hearing and these must be accepted, even though some judges may express initial reluctance to do so. If the records are recent, most judges will not object.

Immediately prior to a hearing, the representative should review the file again to determine what is in it. Items may be missing, in which case the representative will need to resubmit them. Also, the OHA may have records or information in the file of which the representative may not be aware. It is very important that a representative review this information so he or she is not surprised by anything at the hearing.

The amount of time it takes to schedule a hearing varies by OHA. The OHA is required to provide 20 days notice before a hearing is scheduled. Occasionally, a decision can be made without a hearing, based on the medical evidence in the file and the strength of the evidence.

Preparing claimants for hearings

Many claimants have had prior negative interactions with judges that concluded with their incarceration or involuntary commitment to a psychiatric hospital. Therefore, representatives should explain to applicants what to expect. Most hearings are held in small conference rooms or courtrooms; the judge sits on a bench above where the claimant sits. Remind the client that ALJs do not have the authority, at the hearing, to incarcerate or order medical treatment. It is important that clients understand this before their hearings, so that they feel free to speak candidly about all of their mental and physical impairments.

What is the representative's role at the hearing?

At a hearing, the representative may have several responsibilities. A representative should be prepared to take any of the following actions:

- Make an opening statement, citing the specific reasons why the claimant is disabled. The statement should include references to the medical and other evidence that has been submitted.
- Stay quiet while the judge elicits information through direct questioning of the claimant.
- Make a closing statement, intended to persuade the ALJ with the same type of summary given during an opening statement.
- Question the claimant, and any other witnesses, to present the facts that should be highlighted.

What should a representative know about testimony?

In preparing for a hearing, it is important to remember that testimony is intended to expand on the information in the medical records and other evidence. This makes it an invaluable part of any case. When preparing a claimant or another witness to testify, the most important thing is to ensure the claimant's medical limitations are explained as well as possible, without exaggerating. If a claimant exaggerates, the ALJ may find that the testimony is not credible. In such a case, the claim may be denied, even if the medical records and other evidence arguably could support a finding of disability.

The first witness usually will be the claimant. If the claimant is a child, the ALJ may or may not ask him or her to testify, depending on age and ability to provide relevant information. When a child claimant does not testify, a parent typically testifies instead.

When questioning the claimant, or any other witness, hearing rules are not as strict as courtroom rules. However, representatives should be careful not to use leading questions. For example, a proper question is *"You have been diagnosed with depression. On a day when you are feeling depressed, can you describe for me all of the daily activities that you perform?"* It would be improper to ask, *"Isn't it right that on most days, you are stuck at home not doing anything because you are depressed?"* Representatives also should avoid questions that result only in "yes" or "no" answers.

In most cases, other witnesses will include people who know the claimant and see the claimant frequently, people who can testify about his or her daily activities and apparent limitations. However, on rare occasions, a representative may want the claimant's doctor or psychiatrist to testify at the hearing. Typically, a doctor will write a letter; however, if a case is extremely complicated, and the doctor is available, it may be useful to have him or her testify.

Witnesses are especially useful to corroborate key points of the claimant's testimony. However, they must be asked only about matters within their knowledge. For example, it is improper to ask about how much the claimant's back hurts, since the witness cannot have personal knowledge of someone else's back pain and its severity. It would be equally improper to ask a doctor to corroborate a claimant's testimony that he or she takes two–hour naps each day, since the doctor does not see the claimant every day and could not specifically corroborate that the claimant, in fact, takes naps. However, the doctor could testify to whether someone with the claimant's condition might need or want to take two–hour naps.

Medical expert testimony

If the judge deems it necessary, a medical and/or vocational expert will be present at the hearing. The hearing notice will indicate whether the judge is asking experts to be at the hearing. After the claimant and witnesses have testified, the experts will testify.

The job of the medical expert (ME) is to assess all the medical evidence in the case file, as well as the testimony of the claimant and other witnesses. Based on that information, the ME first gives an opinion about whether or not the claimant has a condition that meets or equals any of the SSA listings. If the ME states the claimant meets or equals a listing, the ALJ almost always will stop the hearing and allow the claim. However, because the ALJ is the ultimate decision–maker, he or she is not required to do so.

If the ALJ does not accept the opinion of the ME that the claimant meets or equal a listing, or if the ME's opinion is that the claimant does not meet or equal a listing, the ALJ will ask the ME for an opinion about the claimant's residual functional capacity (RFC). As discussed in Chapter 5, RFC is the claimant's ability to work in relation to his or her previous capacity—for example, it covers

how many hours per work day a claimant could sit, stand, or walk. If the ME's opinion is that a claimant's RFC is so restrictive that he or she is clearly unable to work, the ALJ may stop the hearing and make a finding that the claimant is disabled.

However, if the testimony provided does not result in an ALJ finding that the claimant is disabled, the representative should cross–examine the ME. In the questioning, the representative should review the evidence that suggests the claimant is disabled and make the ME acknowledge it and explain why he or she is not crediting it. It is important to refer to both medical records and medical opinion letters in the case file. It also is critical to ask the ME why he or she has determined that the claimant does not meet a listing or that the claimant has a particular RFC, despite the evidence to the contrary.

Vocational expert testimony

A vocational expert (VE) provides the ALJ with an opinion about whether a hypothetical claimant is able to work based on his or her knowledge about the effect of various vocational factors and functional limitations on the ability to perform work. The VE bases his or her opinion on the RFC provided by the ALJ; the *Dictionary of Occupational Titles* (a Department of Labor publication that describes how occupations are performed in the national economy); other reliable sources of vocational information; professional expertise; and a variety of non-medical factors such as age, education, work history, ability to communicate in English, and transferable job skills. VEs are necessary particularly when a claimant has non-exertional impairments, which can make use of the grids more subjective.

A VE is questioned in a very specific manner. First, the judge will present the VE with one or more hypotheticals, based on the age, work history, and the documented medical and/or vocational impairments of the claimant. For example, a judge will ask:

> *Are there any jobs available in the national economy for a 47–year–old male, with an RFC of less than a full range of sedentary work because he cannot sit for more than 30 minutes without severe pain, cannot stand up for more than 10 minutes without having to sit down, cannot walk for more than one block before needing to sit down and rest, and cannot concentrate for more than an hour at a time because of depression?"*

If the VE says that a person with those limitations cannot perform any jobs, there is no need for further questioning, because he or she has provided a favorable response likely to result in a finding of disability.

However, if the VE says there are jobs that the hypothetical individual can do, the representative cross–examines the VE. This should focus on two things. First, the representative needs to ensure that the judge's initial hypothetical included all of the claimant's impairment–related limitations and restrictions. If not, the representative should ask: *"Of the five jobs just mentioned, could the claimant still do them if she had the following additional limitations and restrictions?"* Then, the representative should

list the additional limitations and restrictions that were not included in the judge's original instruction. If the VE says that there are no jobs that the claimant can do with the additional limitations, cross–examination should be ended.

If the representative has added all of the claimant's limitations, and the VE still identifies jobs available, the representative must try to prove that the claimant cannot do the specific jobs listed by the VE. To do so, the representative should ask the VE to describe the jobs and the skills involved with those jobs. The representative should question the VE about how someone with the claimant's particular limitations could perform the tasks associated with that job.

In this type of questioning, one important factor to consider is the number of consecutive hours the claimant is capable of sitting, standing, and walking. If a claimant cannot perform a job full–time, he or she is not able to perform that job. Ultimately, if the VE concludes the claimant cannot do any jobs, the examination has been a success. However, even if the VE does not concede this point, the ALJ sometimes will rule for the claimant. Since the ALJ has decision–making authority, a favorable decision can be issued, even after a VE states that there are jobs that the claimant can do.

Closing the hearing

At the close of the hearing, the ALJ should provide the representative with a brief opportunity to make a closing statement. The closing statement is a very short summary of why the representative believes that the claimant is disabled. The representative should take advantage of it.

The only other thing that might occur at the close of the hearing is a request for additional information or medical tests. This may arise because the representative has persuaded the judge to hold the record open for a limited period while the representative tries to obtain an additional specified piece of evidence, or because the judge has determined additional evidence is necessary. After these requests are honored, the hearing will be closed.

How to read and understand the ALJ's decision

Unlike the decisions at the initial and reconsideration stages, the ALJ's decision will be lengthy. The decision typically comes with a cover page. The top of that cover page will read "Fully Favorable," "Partially Favorable," or "Unfavorable." An unfavorable decision means it has been determined the claimant is not disabled.

If the decision for SSI eligibility is fully favorable, the claimant's file will be forwarded to the local SSA office; the claimant will be asked to come in for a new financial eligibility determination. The financial eligibility determination is important, since it sets the amount of both retroactive and ongoing SSI benefits the claimant will receive. This will be discussed in more detail later.

If the decision is partially favorable or unfavorable, it can be appealed to the Appeals Council (AC) by filing a Request for Review of Hearing Decision/Order (HA–520) or by writing a letter to SSA. As with other SSA forms, the Request for Review is available at www.socialsecurity.gov, and it must be filed within 60 days of the date printed

on the OHA hearing decision (the 60 day filing period plus the five–day period SSA assumes for delivery of the decision). Either the Request for Review form or a letter must be submitted within the same time frame. Whichever method is chosen, it needs to state the claimant disagrees with the decision and wishes to appeal based on relevant information. The form or the letter can be filed at the local SSA office, the Appeals Council, or the OHA. However, it often is most efficient to file it at the local SSA office where an applicant has a known contact.

Deciding whether to appeal a partially favorable decision

As previously mentioned, partially favorable decisions are less common than full approvals or denials, but they may occur for a variety of reasons. Generally, they involve a finding that the applicant's disability began later than the date stated in the application or that the applicant's disability stopped a certain period of time after the date of application. The question of whether to appeal a partially favorable decision depends on how the decision is written and the applicant's priorities.

One important consideration when considering appeal is that, while rare, a partially favorable SSI decision that is appealed could become an unfavorable decision on appeal. The risk, although not high, is real and considerable. Some applicants may feel that it is worth accepting a partially favorable decision, which provides SSI benefits and Medicaid, rather than risking a reversal at the time of appeal To help evaluate the risk, claimants may consider consulting an attorney before deciding whether to appeal a partially favorable decision.

When should the Appeals Council or Federal Court be used?

The right to file an appeal to the Appeals Council (AC) is absolute. The AC looks at every request for a review, but grants review only where: (1) there appears to be an abuse of discretion by the ALJ; (2) there is an error of law; or (3) the action, findings, or conclusions of the ALJ are not supported by substantial evidence. If a claim does not meet one of these criteria, the AC will not review it.

Because this is a complicated standard, case managers should not continue as representatives once a claim gets to the AC. If a case manager believes that an ALJ decision was wrongfully made, he or she should help the client file an appeal, and then work to find an attorney, or a more experienced non–attorney representative, to review the claim and determine if there are grounds for pursuing the appeal.

When a case reaches the AC, SSA rules allow the claimant to file a new application for benefits, while still pursuing the appeal. This is beneficial for many claimants whose conditions may have worsened since filing the original application. Filing a new application sometimes may result in a favorable decision that provides the claimant with ongoing benefits, while still permitting an appeal in the hope of obtaining retroactive benefits.

If a claim is denied at the AC, an appeal can be filed in Federal court. Any Federal court appeal must be handled by an attorney. Further discussion of Federal court appeals is beyond the scope of this manual.

Summary

SSA offers applicants a number of opportunities to appeal unfavorable and partially favorable decisions. Once an appeal is pursued beyond reconsideration, the first decision an applicant must make is whether to retain an attorney. If an applicant decides to hire an attorney, case managers can still serve an important role. As the person most knowledgeable about the claim (other than the applicant), a case manager can help an attorney organize a case. He or she can also serve as a witness. Additionally, the case manager provides ongoing contact with the applicant throughout the appeals process.

If an applicant decides not to hire an attorney, the case manager can continue to serve as the applicant's representative. In this role, the case manager can help with everything from filing the request for reconsideration to cross–examining witnesses during the hearing.

In the event that the applicant still has an unfavorable determination after the first appeal, he or she can file another appeal with the Appeals Council. Again, a case manager can be helpful by assisting with filing the appeal. However, at this point the case manager should strongly recommend to the applicant that he or she engage an attorney.